

MISSOURI DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-042578-

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 5892

STATE FILE NUMBER

FILED DEC 10 1962

| | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|
| 1. PLACE OF DEATH a. COUNTY JACKSON | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY | | Length of stay in 1b 50 years | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 7311 BELLEFONTAINE | | d. STREET ADDRESS (If outside, give location) 7311 BELLEFONTAINE | |
| 3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM PETER DE WAR, JR. | | 4. DATE OF DEATH Month Day Year NOVEMBER 22, 1962 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 7-7-1880 |
| 9. AGE (last birthday) 82 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | |
| 11. BIRTHPLACE (City and state or country) NEW ORLEANS, LA. | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13a. FATHER'S NAME WILLIAM P. DE WAR | | 13b. MOTHER'S MAIDEN NAME UNKNOWN SLATER | |
| 14. NAME OF HUSBAND OR WIFE Deceased Edna Mae | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO | |
| 16. SOCIAL SECURITY NO. [REDACTED] | | 17. INFORMANT Address Wm. P. De War III, 7311 Bellefontaine, K.C., Mo. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Circulatory Failure</i> DUE TO (b) <i>Arteriosclerotic Heart Disease</i> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | |
| 21. I attended the deceased from _____, to _____ and last saw her/him alive on _____. Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <i>Hugh D. Owens, Coronar</i> | | 22b. ADDRESS 152 N. 1st St. Kansas City, Mo. | |
| 22c. DATE SIGNED 11-23-62 | | 23. NAME OF CEMETERY OR CREMATORY FOREST HILL CEMETERY | |
| 23a. LOCATION (City, town, or county) KANSAS CITY, MISSOURI | | 23b. DATE 11-23-62 | |
| 24. FUNERAL DIRECTOR GEO. C. CARSON & SONS, INDEPENDENCE, MO. | | 25. DATE RECD. BY LOCAL REG. 11-23-62 | |
| 26. REGISTRAR'S SIGNATURE <i>Ruth Long</i> | | | |

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

H. Owens MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Marshall E. Blackwell

Licensed Embalmer No. 4713

P. O. Address Raytown, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.